

COLORADO STATEWIDE CENSUS FOR CHILDREN AND YOUTH WITH COMBINED VISION AND HEARING LOSS (DEAF-BLINDNESS)

Colorado Department of Education / Exceptional Student Services Unit
201 Colfax Avenue, Room 409, Denver, Colorado 80203
Part B Form (only use this form for 3 to 21 year old children and youth)

Please complete the information on this form and return it through the CDE Secure Portal. Please refer to the Explanation of Certain Codes handout to assist you with completing this form. If you have any questions about the content of the Census Form, please call (303) 503-4647 or email Anthony_T@cde.state.co.us.

STUDENT NAME: _____ **ID Code** (CDE will populate): _____

PROGRAM INFORMATION: (if child is under 3 years old you should be using the Part C Form and not this form)

Name of Contact Person: _____ Phone: _____

Contact Person's Work Address: _____ City: _____

State: Colorado Zip Code: _____ Email Address: _____

Name of School District or Administrative Unit (AU): _____

School/Agency Where Student Attends: _____

School/ Agency Address: _____ City: _____

State: Colorado Zip Code: _____

Name of Student's Primary Teacher: _____

Phone:_____ Email Address: _____

Program / Grade: ☐ Preschool ☐ Grade K-12 (note grade): _____ ☐ Secondary Transition

Student's Personal Information

Last Name:_____ First & Middle Name: _____

Date of Birth: _____ Gender: (check one) ☐ Male = 00 ☐ Female = 01 ☐Other = 02

Date Deaf-Blind eligibility determined: (MM/DD/YYY): _____ SASID# _____

Ethnicity (check one) ☐ Not Hispanic ☐ Hispanic/Latino

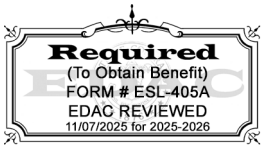
Race: Check **ONE** race code that best describes the student**.**

☐ 1. American Indian or Alaska Native
☐ 2. Asian
☐ 3. Black or African American
☐ 5. White
☐ 6. Native Hawaiian or Other Pacific Islander
☐ 7. Two or more races (no need to specify which races)

Note *# 4 from the form has been deleted to align with federal reporting guidelines*

Primary language in the home (check one) ☐ English = 01 ☐ Spanish = 02 ☐ ASL = 03 ☐ Other ____

FOR OFFICE USE ONLY:



Parent/Guardian Information (Please assure you have the most recent / accurate address information).
Please complete two contact information fields, if parents or legal guardians have two different last names.

Parent Last Name: _____ First Name: _____

Parent Last Name: _____ First Name: _____

Address: _____ City: _____

State: Colorado Zip: _____ County: _____

Telephone: _____ Email: _____

Living Setting: Check the living setting which the student resides the majority of the year.
Check only **ONE** choice.

Living Setting Information

- ☐ 01. Home: With Parents
- ☐ 02. Home: Extended Family
- ☐ 03. Home: Foster Parents
- ☐ 04. State Residential Facility
- ☐ 05. Private Residential Facility
- ☐ 09. Pediatric Nursing Home
- ☐ 10. Community Residence (Includes group home /supported apartment)
- ☐ 555. Other (Specify): _____

***Note**: 6, 7, and 8 from the form have been deleted to align with federal reporting guidelines*

IDEA Category for Current Service: Check Only One Choice.

☐ IDEA Part B = 02 ☐ Not receiving services under IDEA Part B or C = 03 ☐ 504 Plan= 04

Part B Category Code: this is the primary label on the student's Individual Education Program (IEP):

Check the ONE Part B Category Code from the list that identifies the primary eligibility label on the student's Individual Education Program (IEP). For students who are school age (3-21 years) but not enrolled in a public school district, please select the 888 choice.

- ☐ 01. Intellectual Disability
- ☐ 02. Hearing Impairment, Including Deafness
- ☐ 03. Speech or Language Impairment
- ☐ 04. Visual Impairment, Including Blindness
- ☐ 05. Serious Emotional Disability
- ☐ 06. Orthopedic Impairment
- ☐ 07. Other Health Impaired
- ☐ 08. Specific Learning Disability
- ☐ 09. Deaf-Blindness
- ☐ 10. Multiple Disabilities
- ☐ 11. Autism Spectrum Disorder
- ☐ 12. Traumatic Brain Injury
- ☐ 13. Developmental Delay (ages 3 through 8 years)
- ☐ 888. Not Reported under Part B of IDEA

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Check the **ONE** educational setting code from the appropriate age subcategories that best describes the student's education setting. Please find the section that describes the child's age and fill out only that section.

Educational Setting - Complete if Child is Ages Three to Five Years. Check one box.

☐ 301. Services in Regular Early Childhood Program (10+ hours)
☐ 302. Other Location Regular Early Childhood Program (10+ hours)
☐ 303. Services in Regular Early Childhood Program (<10 hours)
☐ 304. Other Location Regular Early Childhood Program (<10 hours)
☐ 305. Attending a Separate Class
☐ 306. Attending a Separate School
☐ 307. Attending a Residential Facility
☐ 309. Home, at public expense
☐ 310. Home, not at public expense
☐ 888. N/A Not a child who is 3-5

Educational Setting - Complete if the Child is Ages Six to 21 Years. Check one box.

☐ 610. Inside the regular class 80% or more of day
☐ 611. Inside the regular class 40% to 79% of day
☐ 612. Inside the regular class less than 40% of day
☐ 613. Separate school
☐ 614. Residential facility
☐ 615. Homebound/Hospital
☐ 616. Correctional facility
☐ 617. Parentally placed in private schools
☐ 620. Home school/remote learning, at public expense
☐ 621. Home school/remote learning, NOT at public expense
☐ 888. N/A Not a child who is 6-21 years

Participation in Statewide Assessments

Check one box best representing the student's participation in the state's assessment activities.

☐ 1. Regular grade-level State Assessment (CMAS at 3rd- 8th grades, PSAT at 9th and 10th, SAT at 11th grade)
☐ 2. Regular grade-level State Assessment (CMAS) with accommodations
☐ 3. Alternate assessment (CoALT at 3rd- 8th and 11th grades)
☐ 6. Not required at age or grade level (infants, toddlers, preschoolers, K-2 grades)
☐ 7. Parent Opt-Out *Note: # 4, 5, and #19 are not applicable with CO state assessments.*

Evidence of a READ Plan: For children in Kindergarten – 3rd Grade, does student have a READ Plan for a Significant Reading Deficiency?

☐ No = 0 ☐ Yes = 1 ☐ Not Applicable =2 (student is a different grade than Kindergarten-3rd Grade)

Primary Identified Etiology: Circle the **ONE** etiology code from the list below that best describes the primary diagnosis for the student's deaf-blindness. Specify "other" etiologies in the line beneath the chart.

Hereditary/Chromosomal Syndromes and Disorders	
101 Aicardi syndrome	130 Marshall syndrome
102 Alport syndrome	131 Maroteaux-Lamy syndrome (MPS VI)
103 Alstrom syndrome	132 Moebius syndrome
104 Apert syndrome (Acrocephalosyndactyly, Type 1)	133 Monosomy 10p
105 Bardet-Biedl syndrome (Laurence Moon-Biedl)	134 Morquio syndrome (MPS IV-B)
106 Batten disease	135 NF1-Neurofibromatosis (von Recklinghausen disease)
107 CHARGE association	136 NF2-Bilateral Acoustic Neurofibromatosis
108 Chromosome 18, Ring 18	137 Norrie disease
109 Cockayne syndrome	138 Optico-Cochleo-Dentate Degeneration
110 Cogan syndrome	139 Pfieffer syndrome
111 Cornelia de Lange	140 Prader-Willi
112 Cri du chat syndrome (Chromosome 5p-syndrome)	141 Pierre-Robin syndrome
113 Crigler-Najjar syndrome	142 Refsum syndrome
114 Crouzon syndrome (Craniofacial Dysotosis)	143 Scheie syndrome (MPS I-S)
115 Dandy Walker syndrome	144 Smith-Lemli-Opitz (SLO) syndrome
116 Down syndrome (Trisomy 21 syndrome)	145 Stickler syndrome
117 Goldenhar syndrome	146 Sturge-Weber syndrome
118 Hand-Schuller-Christian (Histiocytosis X)	147 Treacher Collins syndrome
119 Hallgren syndrome	148 Trisomy 13 (Trisomy 13-15, Patau syndrome)
120 Herpes-Zoster (or Hunt)	149 Trisomy 18 (Edwards syndrome)
121 Hunter syndrome (MPS II)	150 Turner syndrome
122 Hurler syndrome (MPS I-H)	151 Usher I syndrome
123 Kearns-Sayre syndrome	152 Usher II syndrome
124 Klippel-Feil sequence	153 Usher III syndrome
125 Klippel-Trenaunay-Weber syndrome	154 Vogt-Koyanagi-Harada syndrome
126 Kniest Dysplasia	155 Waardenburg syndrome
127 Leber's congenital amaurosis	156 Wildervanck syndrome
128 Leigh Disease	157 Wolf-Hirschhorn syndrome (Trisomy 4p)
129 Marfan syndrome	199 Other _____

Pre-Natal/Congenital Complications	Post-Natal/Non-Congenital Complications
201 Congenital Rubella	301 Asphyxia
202 Congenital Syphilis	302 Direct Trauma to the eye and/or ear
203 Congenital Toxoplasmosis	303 Encephalitis
204 Cytomegalovirus (CMV)	304 Infections
205 Fetal Alcohol syndrome	305 Meningitis
206 Hydrocephaly	306 Severe Head Injury
207 Maternal Drug Use	307 Stroke
208 Microcephaly	308 Tumors
209 Neonatal Herpes Simplex (HSV)	309 Chemically Induced
299 Other _____	399 Other _____

Related to Prematurity	Undiagnosed
401 Complications of Prematurity	501 No Determination of Etiology

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Other Cause of deaf-blindness (please be as specific as possible): _____

_____

_____

Part B Status or Exiting: For students in early childhood/special education (preschool) or school-aged special education (3-21 years) indicate the code that best describes the student's status on December 1st, 2020. If the student is still in a Part B special education program, check 0. If the child has exited from Part B special education services, please indicate the number that best describes the exit reason. Check only one response.

☐ 00. In special education program
☐ 01. Transferred to regular education
☐ 02. Graduated with regular high school diploma
☐ 03. Received a certificate
☐ 04. Reached maximum age
☐ 05. Deceased
☐ 06. Moved, known to be continuing
☐ 08. Dropped out
☐ 22. Graduated with alternate high school diploma
☐ 888. Not applicable - Child not served by Part B

Note: 7 is intentionally not use

Information about the Student's Blindness/Low Vision: Please provide information on the student's most current Functional Vision Assessment, which is a non-clinical assessment conducted by a Teacher of Students with Visual Impairments.

Date of Functional Vision Assessment: _____ By Whom: _____

Does this student have a Learning Media Assessment Plan on file with their IEP? ☐ No = 0 ☐ Yes = 1

Primary Classification of Blindness/Visual Impairment
(Circle One that Best Describes the Student's Blindness / Low Vision status)

1. Low Vision (acuity of 20/70 to 20/200 **in the better eye with correction**.)
2. Legally Blind (acuity of 20/200 or less **or** field loss to 20 degrees or less **in the better eye with correction**.)
3. Light Perception Only
4. Totally Blind
6. Diagnosed Progressive Loss
7. Further Testing Needed to Determine Blindness/Low Vision status (can be selected for one year only)

***Note**: s 5, 8, and 9 from the federal form have been deleted since they do not apply in Colorado*

Does the child have a diagnosis of cortical/cerebral visual impairment? ☐ No = 0 ☐ Yes = 1 ☐ Unknown = 2
Does the child wear corrective lenses (glasses, contacts) (check one): ☐ No = 0 ☐ Yes = 1 ☐ Unknown = 2

Information about the Student's Deafness/Hearing Difference: Please provide information on the student's Functional Hearing Assessment, which is a non-clinical assessment conducted by a Teacher of the Deaf.

Date of Functional Hearing Assessment: _____ By Whom: _____

Does this student have a Communication Plan on file with their IEP? ☐ No = 0 ☐ Yes = 1

Primary Classification of Deafness / Hearing Difference (Circle One that Best Describes the Student's Hearing Status	
1. Mild (26-40 dB loss) 2. Moderate (41-55 dB loss) 3. Moderately Severe (56-70 dB loss)	4. Severe (71-90 dB loss) 5. Profound (91+ dB loss) 6. Diagnosed Progressive Loss
7. Further Testing Needed to Determine Hearing Impairment (can be selected for one year only) ***Note:*** *#s 8 and 9 from the federal form have been deleted since they do not apply in Colorado* Does the student have a central auditory processing disorder? ☐ No = 0 ☐ Yes = 1 ☐ Unknown = 2 Does the student have auditory neuropathy? ☐ No = 0 ☐ Yes = 1 ☐ Unknown = 2 Does the student have a cochlear implant? ☐ No = 0 ☐ Yes = 1 ☐ Unknown = 2 If yes, date of implant: Right: _____ Left: _____ Does the student use Assistive Listening Devices ☐No = 0 ☐ Yes = 1 ☐ Unknown = 2	

Other Concern Areas or Health Needs: Check the concern areas, in addition to the child's combined visual and hearing impairments that have a significant impact on the individual's developmental or educational progress.

Please consider each area carefully and work to not select the choice of unknown as this should be well understood by and known to the educational team.

Orthopedic Disability (e.g., cerebral palsy)	☐ No = 0	☐ Yes = 1	☐ Unknown = 2
Intellectual Disability	☐ No = 0	☐ Yes = 1	☐ Unknown = 2
Serious Emotional Disability (mental health/behavior)	☐ No = 0	☐ Yes = 1	☐ Unknown = 2
Other Health Impairment (e.g., seizure disorder)	☐ No = 0	☐ Yes = 1	☐ Unknown = 2
Speech / Language Impairment	☐ No = 0	☐ Yes = 1	☐ Unknown = 2
Other educational concerns:	☐ No = 0	☐ Yes = 1	

Specify Other Concerns: _____

Information Specific to Equipment and Technology / Intervener Status Specific to this Student

Does the child use additional Assistive Technology ☐ No = 0 ☐ Yes = 01 ☐ Unknown = 02

Does the child receive services from an Intervener ☐ No = 0 ☐ Yes = 01 ☐ Not Applicable = 888

If this child has Intervener, is the intervener: ☐ Credentialed ☐ Certified ☐ Not credentialed or certified

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Deaf-Blind Project Status: Check which number applies to the current status of the student. If the student is still considered to be a learner with deaf-blind needs, check 0. If the student is no longer considered to be deaf-blind, please check #1.

☐ 0. Eligible to receive services from the State Deaf-Blind Project (student is deaf-blind)
☐ 1. No longer eligible to receive services from the State Deaf-Blind Project (no longer deaf-blind)

Notes: _____

_____

_____

Please file a copy of this form in the student's file in your administrative unit / agency. The original should be sent through the CDE Secure File Transfer Server.

If there are any questions about this form, please contact Dr. Anthony at (303) 503-4647 or Anthony_t@cde.state.co.us. This form must be signed by a district / agency contact person.

Signature: _____ Date: _____

Title: _____

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